COMMENTARY

ON SCREENING IN MANAGED CARE

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A Public Health Standard for Screening Managed Care Populations

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Managed care offers public health a set of opportunities to accomplish the goal of improving health status; among which is the chance to apply useful interventions to all members of a targeted population. The Department of Health and Human Service's New England Regional Office is working with our six state health commissioners and the major managed care plans in the region to create an alliance to take advantage of these new possibilities (see box). Our brief experience brings us a new perspective on how managed care can assist with public health and prevention.

In this issue, Davis et al. discuss an admirable undertaking. The authors evaluated the efforts of three managed care plans to apply the purportedly useful screening guidelines of the National Cholesterol Education Program to members of the enrolled population who might benefit from a high blood cholesterol screening and the appropriate follow-up.

Having commended the objective of the managed care plan's efforts, it is important to spell out three critical caveats, as we are likely to see many more such screening programs. Questions of this sort are worth asking in all cases.

1. Has the managed care plan reviewed the literature correctly and applied the appropriate intervention or screening test to the proper element of their enrolled population?

In this case the screeners applied the guidelines of the National Cholesterol Education Program. This is probably not an unreasonable choice,

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but their text does not adequately reflect the continuing controversy over what is the most effective screening and follow-up for elevated cholesterol levels.

2. Is it appropriate to limit the medical records review to a population that has been enrolled for a long time?

Davis et al. studied only those managed care plan members who had been continuously enrolled for at least five years. Although this selection rule comported with the "every five year" screening recommendation, it selects a population distinctly different from the whole membership of most managed care plans. Instead, the authors might have looked at all members' records and divided by each member's length of enrollment to create a screening rate.

Part of the rationale for managed care and market driven reforms is that consumers vote with their feet, switching from one plan to another to get the kind of care they want. When this tendency to disenroll and enroll elsewhere is compounded by the assignment to managed care plans of Medicaid enrollees, who may remain enrolled for only short periods of eligibility, selecting for enrollees of long duration may skew the data. One suspects that the selection rule chosen by Davis et al. makes the results look far better than asking the question for the whole enrolled population at any point in time. Is their desire to market managed care influencing the research?

3. What is the appropriate target level for screening or interventions among managed care enrollees?

The 75% target that Davis et al. used was taken from a national goal, intended to include both unenrolled fee-for-service users and managed care enrollees. Public health agencies have always made realistic allowances for screening programs that had to depend on outreach and public education to bring citizens in to see the doctor. Managed care, with enrolled members, should not be granted such a handicap. Although they may not achieve it at the start, it seems reasonable that managed care plans should be expected to reach 100% of their enrolled members.

Unless we hold managed care plans to the same kind of high, population-based standards that we in public health use when we try to protect the whole population, we will have failed to get the full health benefit of an increasingly organized medical care system. ■

NEW ENGLAND PUBLIC HEALTH AND MANAGED CARE INITIATIVE

New England has the highest penetration of managed care in the country; most of the region's managed care organizations are not-for-profit. Because only the judicial system is organized at the county level in New England, the six state health departments dominate the public health scene. In 1997, the Regional Office of the Department of Health and Human Services, with the help of the George Washington University Center for Health Policy Research, approached the six New England health commissioners and about two dozen managed care organizations with an invitation to collaborate to improve public health in the region.

The thinking behind this initiative is that, as enrollment in managed care appoaches universality, public health agencies may be able to rely on managed care plans to assist in public health functions and managed care plans may be able to rely on community interventions from public health departments to protect their enrollees. To test this hypothesis, the New England public health and managed care collaboration will begin by addressing three problems: asthma, tobacco use, and vaccinating adults.

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